Why Lesbian, Gay, Bisexual, and Transgender Public Health?

During the past few years public health has begun to address the concerns of lesbian, gay, bisexual, and transgender (LGBT) populations. This special issue of the Journal, the first issue dedicated to this subject in the Journal's 91-year history, is preceded by an American Public Health Association resolution on the need for research on the relationship between disease and gender identity and sexual orientation,[1] an Institute of Medicine report on lesbian health,[2] and the inclusion of gays and lesbians among groups targeted for reducing disparities in health outcomes in the US government's 10-year blueprint for public health.[3] But do LGBT populations present a viable topic for public health investigation and intervention? What makes their concerns a distinctive health topic? Finally, addressing social issues through a public health prism holds both promise and peril[4]—might public health attention to LGBT populations harm LGBT people?

LGBT People and Communities

LGBT persons vary in sociodemographic characteristics such as cultural, ethnic, or racial identity; age; education; income; and place of residence. They are also diverse in the degree to which their LGBT identities are central to their self-definition, their level of affiliation with other LGBT people, and their rejection or acceptance of societal stereotypes and prejudice. By using the plural "LGBT populations," I also aim to stress that, like the people they comprise, these populations or communities are diverse.

There are various gay male, lesbian, bisexual, and transgender populations: urban and rural, White and Black, poor and wealthy, and so forth. We refer to all of these as LGBT communities, but in doing so we risk glossing over important differences. White gay men in New York City's Chelsea neighborhood share little with transgender sex workers just a few blocks away in Greenwich Village; with gay men developing a gay liberation movement in Guadalajara, Mexico; with lesbians in Northhampton, Mass; or with bisexual married women on Long Island, NY. "Transgender" refers to such a variety of individuals, from intersexed newborns to heterosexually identified transvestite men, that any discussion of transgender people as a group would distort the group's diversity.[5] Moreover, LGBT people may have more in common with their non-LGBT communities than with LGBT communities. For example, African American gay and bisexual men who belong to a church in Chicago's South Side may share more attitudes, beliefs, and norms with fellow African American church members than with lesbians or gay men in Chicago's White gay community.

Finally, public health research in the context of the AIDS epidemic has brought the recognition that not all men and women who have sex with people of the same gender share a gay or lesbian identity. The terms "men who have sex with men" and "women who have sex with women" are commonplace in public health discourse. But these terms should be used with caution; although they are respectful of the variety of sexualities, they erase important self-definitions and identities of gay men, lesbians, or bisexuals. It is particularly worrisome when these terms are applied universally to people of color, betraying an often erroneous assumption that owning a gay identity is the privilege of only White men and women. This assumption goes against both the historical record and current research that demonstrates the existence of thriving gay cultures among various ethnic groups in the United States and abroad.[6,7]

Despite the many differences that separate them, LGBT people share remarkably similar experiences related to stigma, discrimination, rejection, and violence across cultures and locales.[6,8–10] In the United States, gay men and lesbians are subject to legal discrimination in housing, employment, and basic civil rights. Sodomy laws, which brand gays and lesbians as criminals in 16 states, are often the basis for harassment and discrimination. Transgender individuals are stigmatized, discriminated against, and ridiculed in encounters with even those entrusted with their care.[11] LGBT people fare better in some areas (e.g., parts of the European Community) than in others, but they are still subject to persecution and discrimination in many regions of the world.

LGBT people have formed communities that bridge their many differences. These communities have provided safe spaces, developed norms and values, and created institutions where LGBT identities and relationships can be acknowledged and respected.[10,12,13]

LGBT Issues in Public Health

Social conditions that are characterized by rejection and discrimination distinguish the public health of LGBT populations because they affect a wide range of issues, including the selection of research priorities, the design of public health prevention and intervention programs, the development of standards of care, access to care, and the provision of culturally sensitive care. Stigma and discrimination affect the health of LGBT people in many ways. Direct routes are easily discernable: they include exposure to violence and discrimination and poor clinical care. Indirect routes are invisible but more pervasive: they include inadequate attention to health concerns of LGBT people because of stereotypic thinking, lack of attention to LGBT health issues because they affect only a relatively small number of people, and lack of knowledge and insensitivity regarding the cultural concerns of LGBT people.

It may be useful to categorize LGBT issues in public health as (1) areas in which LGBT people are at an increased risk for disease because of unique exposures, (2) areas in which they have high prevalences of diseases or problems that are not caused by unique exposures, and (3) areas in which they are not at increased risk for disease but which nevertheless require specialized culturally competent approaches. Clearly, these categories cover the whole spectrum of health and illness.

Unique exposures to risk are exposures related to sexual behaviors, sexual orientation, and gender identity. This issue demonstrates the most direct relevance of focusing on sexual orientation in public health. The area most often addressed under this category is risk related to sexual behavior (e.g., anal intercourse, which places men who have sex with men at risk for HIV and other sexually transmitted diseases). Just as important, however, are risks related to social conditions characterized by prejudice, discrimination, and rejection (e.g., anti-gay violence or minority stress—the excess stress experienced by minorities). Such risks may have direct impacts on the incidence of mental and somatic disorders, as well as access to care, health care utilization, and quality of care.[14–17] Prejudice about same-sex sexuality or gender roles can also lead to the design of insensitive and alienating public health interventions and prevention programs that fail to respect the values and needs of LGBT communities.[18]

LGBT people may be at high risk for problems that are not directly related to sexual orientation or gender identity (e.g., smoking, obesity, and alcohol and drug use).[19] Although such problems are not unique to LGBT people, to the extent that they have a higher prevalence among LGBT populations they require special public health attention and unique approaches for investigation, prevention, and treatment. Often, models explaining these risks fail to account for the unique social or behavioral dynamics of these populations, but attention to these characteristics may explain the high prevalence of those risks. The Substance Abuse and Mental Health Services Administration's effort in the area of substance use is one example of an effort to address common risks in a specialized manner.[20]

Finally, all public health areas, even those in which LGBT populations do not have a unique or increased risk for disease, may require a specialized focus for these populations. For example, provision of adequate care requires that care providers be sensitive to the needs of these populations. Insensitive or hostile care may lead to inappropriate interventions, fail to effect change, and add to alienation and mistrust of the authority of public health recommendations.[21]

Obstacles to Quality Research

Many obstacles stand in the way of our gathering knowledge about LGBT populations. Some are methodological; others are related to homophobia and heterosexism, which place LGBT studies outside the mainstream in terms of importance and allocation of resources. Methodological obstacles are serious and may have thwarted effective research on LGBT public health issues. Large-scale random surveys of LGBT populations are expensive; with few resources, public health researchers and planners have often turned to small studies that use samples of convenience. Such data may be biased and uninformative for many public health purposes. For example, one area in which lack of good data has recently frustrated researchers is the study of anal cancer in gay men and breast cancer in lesbians; some studies have suggested that lesbian, gay, and bisexual (LGB) people have a higher incidence of these cancers and a shorter survival time. Another area is psychiatric epidemiology; studies present inconsistent findings on the prevalence of psychiatric disorders and suicide among lesbian and gay youths and adults.[22]

Several researchers advocate the inclusion of LGB populations in government studies that use random sampling techniques. Collecting data on sexual behavior and orientation in large epidemiologic studies that utilize random samples of the US population would be useful for many purposes.[2,23] Yet it should be stressed that large-scale random surveys are not always the best approach to sampling gay men and lesbians and are clearly problematic for transgender populations, which are even more heterogeneous, rare, and dispersed. Large-scale studies typically identify very few LGB individuals. Although they are useful for preliminary data, their samples often preclude detailed analyses relevant to LGBT populations. For example, the low number of LGB respondents identified in a US probability survey of mental health did not allow the investigators to study variability in the LGB group.[24] Large-scale studies should not replace targeted research.

Other approaches to sampling, some discussed in this issue of the Journal, have been developed and used to address issues related to LGBT health.[6,17,25,26] It is also important to note that these research challenges are not unique to LGBT populations. Researchers surveying any other rare population (ethnic minority groups, specific age groups, residents of rural areas) meet similar challenges. Methodological obstacles should not be used to excuse lack of funding or action.

Although the methodological obstacles are serious, they are not insurmountable. The effects of institutional and individual homophobia and heterosexism on research may prove more difficult to deal with. Homophobia and heterosexism need not be active or intentional; they may affect policies and attitudes indirectly and unintentionally, for example, by defining LGBT issues as marginal to concerns of the general population, by constructing them as exotic or difficult to study, or by viewing them as too political or too sensitive.[27]

Public health has a good example to follow in the US government's efforts to include women and ethnic minorities in research. Recently researchers and policymakers have become aware of the role of income inequalities in health. But sexual minorities continue to be stigmatized groups whose neglect is often justified by political, moral, or religious beliefs. Thus, calls for programs and proposals on non–HIV-related LGBT health issues have been rare, funding of research has been slow, and publication of existing research has been scant.

In turn, lack of data on LGBT populations has led to the neglect of important health issues. For example, lack of data hindered the inclusion of sexual orientation in the US government's Healthy People 2010,[3] which set health priorities for the next decade. But even a quick review of the Healthy People 2010 document reveals that goals for many populations are based on less than perfect research methodologies, suggesting that a higher standard was applied to the inclusion of sexual orientation. This potential harm was somewhat mitigated by the lobbying efforts of the Gay and Lesbian Medical Association, which opened the way for publication of research needs of LGBT populations by the Center for Lesbian, Gay, Bisexual and Transgender Health at Co-

lumbia University's Mailman School of Public Health and the inclusion of LGB concerns in 29 health objectives in the final Healthy People 2010 document.

Research methodologies need to be improved, but existing research should not be ignored even when it is limited. For example, early research on suicide among LGBT youths has been plagued by poor methodologies and biased samples.[28] Calls for more attention to LGBT mental health have been muffled by legitimate criticism of the methodology used in studies that these calls relied on.[29] Now methodologically sound research has substantiated the main thrust, if not the exact findings, of earlier reports.[30,31] That this special issue of the Journal attracted close to 100 submissions even without a formal call for papers suggests that there is an eager group of researchers for whom LGBT health is important. Several researchers told us that the expected publication of this special issue led them to embark on analyses of data that they had not anticipated would be of interest to major journals. These analyses in turn yielded important public health data.

Promise and Peril

Enthusiasm about the growing attention to LGBT populations in public health must not blind us to the risks. A focus on LGBT populations in public health, in particular when followed by calls for proposals and programs and resources, would bring institutional and governmental control over the content and structure of such programs. For a stigmatized minority, this institutional control could prove limiting. The same social forces, including homophobia, heterosexism, and sexism, that have previously led to exclusion might now lead to inappropriate and even damaging programs.

Placing sexuality, sexual orientation, and gender under a public health lens may lead to their medicalization and "public healthification"[4] and to the institutionalization of negative attitudes.[32] Research on epistemology has demonstrated that moral and religious beliefs have become incorporated into scientific knowledge.[33] Especially damaging was the incorporation of attitudes about homosexuality and gender roles into psychiatric models, transforming sin into a medical disorder.[34–36] The criticism that public health efforts in HIV prevention have been riddled with sex-phobic messages that fail to account for the importance of sexual expression—in particular, anal sex—for gay and bisexual men is a recent example of the potential for peril.[18,37] As efforts to focus on LGBT health proliferate, we may see that for every sensitive effort to include the target population in decision making,[21] there may be another program that seeks to restore health by eliminating practices essential to self-expression and identity, leading to alienation and damage.

This is particularly a danger if the need for careful consideration of the diversity represented by categories of sexuality, gender, and sexual orientation is replaced by a more unified approach to LGBT health in which generalities replace complexities. An institutionalized focus on LGBT health may also lead to oversimplification and elision of important differences among populations and individuals. Similarly, programs that appease some groups may be hailed as progress and accepted even when they exclude many others. For example, in a familiar play of power and ethics, despite preliminary efforts to address transgender health issues in Healthy People 2010,[22] these issues were not included in the final document.

There is also danger in plans for centralized governmental collection of data on sexual orientation in US population studies, particularly if such data are collected without attention to economic, ethnic, or geographic variations. With homosexual behavior still criminalized in 16 states, and with prejudice and discrimination a threat everywhere, requests for such data should come with protections of individual rights. Otherwise, respondents' disclosure of homosexual behavior in such surveys will be limited and will surely underestimate true percentages.

More important, biased patterns of disclosure may lead to biased findings about important health correlates. And while large-scale studies would allow comparisons between LGB groups and the general population, they might hide intragroup variability. Such comparisons introduce bias and fail to provide insight into processes that occur in LGBT populations. Finally, the provision of institutional resources and programs can thwart grassroots efforts, because institutions are likely to make funding conditional and more progressive efforts will be inhibited by fear of losing institutional support.

These perils are not inescapable; they demonstrate the need for caution and sensitivity in the effort to bring LGBT issues into public health focus. But the promise of focusing on LGBT health is clear: It can bring much-needed resources, improved research methodologies, and knowledge to bear on the search for innovative approaches to health promotion and disease prevention and treatment. □

Ilan H. Meyer, PhD
Guest Editor

Requests for reprints should be sent to Ilan H. Meyer, PhD, Division of Sociomedical Sciences, Mailman School of Public Health, 600 W 168th St, New York, NY 10032 (e-mail: im15@columbia.edu).

This editorial was accepted March 7, 2001.

Acknowledgments

The author thanks Sharon Schwartz and Daniel Wolfe for insightful comments on an earlier version of this editorial.

References

1. APHA policy statement 9819: the need for public health research on gender identity and sexual orientation. *Am J Public Health.* 1999;89:444–445.
2. Committee on Lesbian Health Research Priorities, Institute of Medicine. *Lesbian Health: Current Assessment and Direction for the Future.* Washington, DC: National Academy Press; 1999.
3. *Healthy People 2010.* Vol 1 and 2. 2nd ed. Washington, DC: US Dept of Health and Human Services; 2000.
4. Meyer IH, Schwartz S. Social issues as public health: promise and peril. *Am J Public Health.* 2000;90:1189–1191.
5. Lombardi E. Enhancing transgender health care. *Am J Public Health.* 2001;91:869–872.
6. Diaz RM, Ayala G, Bein E, Jenne J, Marin BV. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities. *Am J Public Health.* 2001:91:927–932.
7. Chauncey G. *Gay New York : Gender, Urban Culture, and the Making of the Gay Male World, 1890–1940.* Chicago, Ill: University of Chicago Press; 1994.
8. Herek GM. The psychology of sexual prejudice. *Curr Dir Psychol Sci.* 2000;9:19–22.
9. Fullilove MT, Fullilove RE. Stigma as an obstacle to AIDS action. *Am Behav Sci.* 1999;42:1117–1129.
10. Espin OM. Issues of identity in the psychology of Latina lesbians. In: Garnets LD, Kimmel DC, eds. *Psychological Perspectives on Lesbian and Gay Male Experiences.* New York, NY: Columbia University Press; 2001:348–363.
11. Feinberg L. Trans health crisis: for us it's life or death. *Am J Public Health.* 2001;91:897–900.
12. D'Emilio J. *Sexual Politics, Sexual Communities: The Making of a Homosexual Minority in the United States, 1940–1970.* Chicago, Ill: University of Chicago Press; 1983.
13. Weston K. *Families We Choose: Lesbians, Gays, Kinship.* New York, NY: Columbia University Press; 1991.
14. Garnets LD, Herek GM, Levy B. Violence and victimization of lesbians and gay men: mental health consequences. *J Interpersonal Violence.* 1990;5:366–383.
15. Cole SW, Kemeny ME, Taylor SE, Visscher BR. Elevated physical health risk among gay men who conceal their homosexual identity. *Health Psychol.* 1996;15:243–251.
16. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav.* 1995;36:38–56.
17. Clements-Nolle K, Marx R, Guzman R, Katz M. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *Am J Public Health.* 2001;91:915–921.
18. Odets W. Why we stopped doing primary prevention for gay men in 1985. In: Dangerous Bedfellows, eds. *Policing Public Sex.* Boston, Mass: South End Press, 1996:115–140.

19. Aaron DJ, Markovic N, Danielson ME, Honnold JA, Janosky JE, Schmidt NJ. Behavioral risk factors for disease and preventive health practices among lesbians. *Am J Public Health.* 2001;91:972–975.
20. Craft EM, Mulvey KP. Addressing lesbian, gay, bisexual, and transgender issues from the inside: one federal agency's approach. *Am J Public Health*. 2001;91:889–891.
21. Clark ME, Landers, S, Linde R, Sperber J. The GLBT Health Access Project: a state-funded effort to improve access to care. *Am J Public Health.* 2001;91:895–896.
22. Dean L, Meyer IH, Robinson K, et al. Lesbian, gay, bisexual, and transgender health: findings and concerns. *J Gay Lesbian Med Assoc.* 2000; 4:101–151.
23. Sell RL, Becker JB. Sexual orientation data collection and progress toward Healthy People 2010. *Am J Public Health.* 2001;91:876–882.
24. Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D, Kessler RC. Risks of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. *Am J Public Health.* 2001;91:933–939.
25. Stueve A, O'Donnell LN, Duran R, San Doval A, Blome J. Time–space sampling in minority communities: results with young Latino men who have sex with men. *Am J Public Health.* 2001;91:922–926.
26. Catania JA, Osmond D, Stall RD, et al. The continuing HIV epidemic among men who have sex with men. *Am J Public Health*. 2001;91: 907–914.
27. de Gruchy J, Lewin S. Ethics that exclude: the role of ethics committees in lesbian and gay health research in South Africa. *Am J Public Health.* 2001;91:865–868.
28. Muehrer P. Suicide and sexual orientation: a critical summary of recent research and directions for future research. *Suicide Life Threat Behav.* 1995;25(suppl):72–81.
29. Gibson P. *Gay Men and Lesbian Youth Suicide: Report of the Secretary's Task Force on Youth Suicide.* Washington, DC: US Dept of Health and Human Services; 1989;3:110–142.
30. Herrell R, Goldberg J, True WR, et al. Sexual orientation and suicidality: a co-twin control study in adult men. *Arch Gen Psychiatry.* 1999; 56:867–874.
31. Cochran SD, Mays VM. Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: results from NHANES III. *Am J Public Health.* 2000; 90:573–578.
32. Zola IK. Medicine as an institution of social control. In: Conard P, Kern R, eds. *The Sociology of Health and Illness: Critical Perspectives.* New York, NY: St. Martin's Press; 1973: 511–527.
33. Foucault M. *The Birth of the Clinic: An Archaeology of Medical Perception.* New York, NY: Pantheon Books; 1973.
34. Bayer R. *Homosexuality and American Psychiatry: The Politics of Diagnosis.* New York, NY: Basic Books; 2001.
35. Bullough VL. *Homosexuality: A History.* New York, NY: New American Library; 1979.
36. Szasz TS. *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement.* New York, NY: Harper & Row; 1970.
37. Treichler PA. AIDS, homophobia, and biomedical discourse: an epidemic of signification. In: *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS.* Durham, NC: Duke University Press, 1999:11–41.